

UNITED STATES MARINE CORPS
Logistics Operations School
Marine Corps Combat Service Support Schools
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RLO

D117

STUDENT OUTLINE

HEALTH SERVICE SUPPORT

LEARNING OBJECTIVES

1. Terminal Learning Objective: Given the requirement to provide Health Service Support (HSS), commander's guidance, the concept of Combat Service Support (CSS), and the references, coordinate Health Service Support, to ensure Health Service Support requirements are incorporated into the CSS plan. (0402.06.01)

2. Enabling Learning Objectives:

a. Given the references, commander's guidance, the concept of CSS, and a written test, identify the capabilities of Health Service Support (HSS) organizations, per the references. (0402.06.01a)

(1) Define the mission of HSS.

(2) Identify the five functions of HSS.

(3) Identify the levels of care.

(4) Identify the principles of HSS.

(5) Identify the HSS organizations of the operating forces.

b. Given the references, commander's guidance, the concept of CSS, and a written test, identify casualty evacuation procedures, per the references. (0402.06.01b)

(1) Describe the stages of HSS during an amphibious assault.

(2) Define medical regulating.

(3) Identify the five triage category codes.

(4) Identify the four aeromedical evacuation priorities.

OUTLINE

1. MISSION. The mission of Health Service Support (HSS) is to minimize the effects that wounds, injuries, and disease have on units' effectiveness, readiness, and morale. The mission is accomplished by a preventive medicine program that safeguards against potential health risks and by establishing a HSS system. A HSS system is one that provides support from the point of wounding, injury, or illness and evacuation to a Medical Treatment Facility (MTF) that can provide the appropriate level of care. HSS promotes wellness and ensures quality of life to strengthen the human component of military forces against disease and injury.

2. HEALTH SERVICE SUPPORT FUNCTIONS

a. Health Maintenance. This function includes those tasks required to ensure the medical and dental readiness of the unit and its personnel. This is accomplished through routine sick call, physical examinations, preventive medicine, dental maintenance, medical and dental record maintenance, and reports submission.

b. Casualty Collection. This function includes the requirement for all units to plan for the selection and manning of locations where casualties are assembled, triaged, treated, protected from further injury, and then evacuated.

c. Casualty Treatment. This function includes the provision of care which is within a unit's capability. Tasks include triage and treatment (self-aid, buddy-aid, and initial resuscitative care).

d. Temporary Casualty Holding. This function includes those facilities and services required to hold sick, wounded, and injured personnel for a limited time, usually not to exceed 72 hours. Within the USMC operating forces, only the Medical Battalion is staffed and equipped to provide this function.

e. Casualty Evacuation. This function includes those tasks associated with the movement and ongoing treatment of the sick, wounded, or injured while in transit to medical treatment facilities. All USMC units have an evacuation capability by ground, air, or sea.

3. LEVELS OF CARE. HSS within an Area of Operations is organized into levels of care within the continuum that extends rearward throughout the theater, to contiguous theaters, all the way to the Continental United States (CONUS). Each level is designed to provide the mobility and capability required to meet the basic healthcare needs of the supported units, yet provide progressive and phased treatment, hospitalization, and evacuation of the sick and injured. There are five levels of care provided by the Fleet Medical Support System. Two of these, level I and II, are within the capability of organic medical and dental elements of the operating forces. The five levels of care are:

(1) Level I: First Response

(a) Unit Hospital Corpsman (First Aid). The company corpsman represents the first point at which a sick, injured, or wounded Marine / Sailor might receive attention from HSS personnel. Emergency or lifesaving measures required prior to a hospital corpsman's care must be performed by fellow Marines trained in first aid / buddy aid. Care rendered by unit corpsmen includes examination and evaluation followed by emergency or lifesaving measures such as maintenance of airway, control of bleeding, and prevention and control of shock and further injury. The corpsmans duties incorporate application of basic medical skills, effective utilization of medical equipment/supplies, and initiation of appropriate requests for assistance and evacuation.

(b) Aid Station. This level of treatment is characteristic of a battalion aid station (BAS) and is distinguished by the availability of a physician's clinical judgment and skills. Medical treatment is provided in a relatively safe environment with sufficient time to accomplish a more complete evaluation and to initiate an appropriate plan of treatment. Treatment may include restoration of airway by surgical procedure, use of intravenous fluids, antibiotics, and application of appropriate splints and bandages. These more comprehensive elements of medical management prepare

patients for return to duty or for transportation to the level of treatment demanded by their condition.

(2) Level II: Forward Resuscitative Surgery. This level of treatment is characteristic of a Shock Trauma Platoon (STP), or a Surgical Company, Medical Bn, or Casualty Receiving and Treatment Ship. This level of care is distinguished by the application of clinical judgment and skill by a team of physicians and nurses, supported by a medical technician staff. This level of care includes surgical capability, basic laboratory, pharmacy, and holding ward facilities. At this level, necessary examinations and observations can be accomplished in a deliberate manner. The objective of this phase of treatment is to perform those emergency surgical procedures which, in themselves, constitute resuscitation and, without which, death or serious loss of limb or body function is likely to occur. For those patients who require a more comprehensive scope of treatment, arrangements are made for surface or air evacuation to a facility which can provide the required treatment.

(3) Level III: Theater Hospitalization. This level of care is normally provided at combat zone fleet hospitals and hospital ships. The scope of treatment requires clinical capabilities normally found only in a hospital properly staffed, equipped, and located in an environment with a low level of threat from enemy action. The level of care is adapted to the condition and specific need of the patient. For a given patient, it may be the initial step toward restoration of functional health, as distinguished from procedures which stabilize a condition or prolong life. Unhampered by the crisis aspects of forward resuscitative surgery, this level of care may proceed with a greater degree of deliberation and preparation and provide many patients with the definitive treatment that is needed to return them to full duty.

(4) Level IV: En Route Care. This level of care is adapted to the precise condition of a patient. Such care is normally provided by a fully staffed hospital, and embraces those endeavors necessary to complete the patient's recovery. En route care constitutes all that is needed to return the majority of patients to full and useful duty and is normally provided by a combat zone fleet hospital or overseas hospital.

(5) Level V: CONUS Based Definitive Care. Convalescent, restorative, and rehabilitative treatment are

normally provided by military and/or veterans affairs hospitals in CONUS. The convalescent phase of medical support is a period of minimal care and increasing physical activity necessary to restore a patient to functional health and allow his return to duty. Patients requiring restorative and rehabilitative treatment are normally not candidates for return to full duty.

While the five levels of care have been addressed in relation to combat wounds and injuries, the same basic philosophy applies to patients who suffer illness, disease, or non-battle injury. Virtually all treatment phases for relatively minor conditions may be accomplished at the more forward echelons of care. Medical treatment facilities functioning in a combat environment must maintain a high degree of flexibility and mobility. Unexpected changes in the tactical situation will likely require deviations in patient care and treatment phases.

4. PRINCIPLES. The HSS principles are guides for planning, organizing, managing, and executing support. The identification and prioritization of these principles are essential to establishing effective HSS.

a. Conformity - integrate and comply with the commander's intent and plan.

b. Proximity - provide HSS as close to combat operations as the tactical situation permits.

c. Flexibility - maintain the ability to shift HSS resources to meet changing requirements.

d. Mobility - anticipate requirements for rapid movement of HSS units to support combat forces during operations.

e. Continuity - provide optimum, uninterrupted care and treatment to the wounded, injured, and sick.

f. Coordination - ensure that HSS resources in short supply are efficiently employed and used effectively to support operations.

5. HSS ORGANIZATIONS OF THE OPERATING FORCES. HSS is a mission area common to every MAGTF, regardless of the mission. Definitive operational planning for HSS is always an integral part of all MAGTF operations. The inherent flexibility in the

MAGTF and the broad spectrum of potential MAGTF missions call for equal flexibility in HSS execution. The size, type, and configuration of HSS capabilities needed to effectively support a MAGTF will be determined by mission, enemy, terrain and weather, troops and fire support available, time, space, and logistics (METT-TSL).

a. Marine Division

(1) Division Surgeon. The division surgeon functions as a special staff officer under cognizance of the AC/S G-4. The division surgeon advises the division commander in matters relating to the health of the command. The division medical staff includes, in addition to the division surgeon, a medical planner / administrator, a psychiatrist and hospital corpsmen. In conjunction with the AC/S G-4 they determine the internal medical support requirements, allocate organic medical resources, and establish priorities for medical support.

(2) Infantry Regiment. The Infantry Regiment medical section is organic to headquarters company of the regiment and provides medical support for regimental headquarters personnel. When a Battalion Aid Station (BAS) is located near the regimental headquarters, it may not be necessary to establish a Regimental Aid Station. In such event, regimental medical personnel should augment the BAS, and regimental headquarters personnel should use the combined facility.

(3) Infantry Battalion. The Infantry Battalion has organic medical assets consisting of two medical officers and 65 hospital corpsman. These assets constitute the medical platoon of the battalion's H&S Co. The battalion surgeon assigns medical personnel to the line and weapons companies, as needed. The battalion surgeon is responsible for the HSS organization, planning, training, and operation within the battalion. He will coordinate HSS measures with the battalion S-3 and S-4 during training and operations.

(4) Separate Combat Support Battalions. Composition of medical sections in separate battalions varies in proportion to total battalion strength and expected casualty rates. When detachments or elements of separate battalions operate in areas remote from the parent unit, medical personnel are assigned, as required, from the parent battalion.

b. Marine Aircraft Wing. The uniqueness of aviation medicine requires that wing health service support have inherent flexibility. When based where station facilities are available, wing medical personnel are integrated with station personnel to the extent considered appropriate by the wing medical officer and subject to concurrence by the commanding general of the wing concerned, or higher authority. Provisions must be made to support each independent tactical employment. The wing medical officer responsibilities are the same as the division surgeon. The medical staff of the Marine Aircraft Wing includes, in addition to the wing surgeon, a medical planner / administrative officer, environmental health officer, industrial hygienist, optometrist, and hospital corpsmen.

(1) Marine Wing Support Squadron. Organic to each MWSS are a medical officer, hospital corpsmen, and AMAL's adequate to establish a squadron aid station capable of providing medical care to one Marine Aircraft Group. MWSS aid stations form the primary medical facilities of the MAW while deployed. In addition to routine sick call, each MWSS aid station provides aviation medicine, preventive medicine, laboratory, X-ray, and pharmacy services.

c. Force Service Support Group. Medical support organic to the FSSG is divided into those elements designed to provide internal health service support to the FSSG and those elements designed to provide health service support to the entire MAGTF.

(1) Internal Support

(a) Group Surgeon. The group surgeon is a special staff officer, under the cognizance of the AC/S G-4. He advises the FSSG commander on matters relating to the health of the FSSG and the adequacy of internal FSSG HSS. He also supervises the operation of the Group Aid Station (GAS) and has duties similar to the division surgeon.

(b) Group Aid Station (GAS). The GAS provides organic medical support to the FSSG. It is administratively under H&S Battalion, FSSG.

(2) External Support

(a) Health Service Support Officer (HSSO). The HSSO

reviews medical support requirements of operational plans and supporting logistics and CSS annexes. In conjunction with the group surgeon, medical and dental battalion commanders, and company commander of the Medical Logistics Company, the HSSO evaluates needs and develops FSSG HSS responses which will satisfy support requirements beyond the organic capability of the GCE and ACE. The HSSO serves as the officer in charge of the medical section of the FSSG Combat Service Support Operations Center.

(b) Health Service Support Unit (HSSU). The HSSU falls under the cognizance of the AC/S G-3, FSSG. It is supervised by the HSSO. The mission of the HSSU is to coordinate requirements for HSS and class VIII supply support to units external to the FSSG, including MAGTF's.

(3) Medical Battalion. Within the MEF, the Medical Battalion is the only source of Level II Care, Forward Resuscitative Surgery. The primary purpose of the medical treatment facilities of the battalion is to provide initial resuscitative care. Treatment capabilities include emergency surgical procedures which, in themselves, constitute resuscitation and without which, death or serious loss of limb or body function is likely. The beds in these facilities are classified as flow through beds which provide a temporary casualty holding capability. The battalion is structured to provide 260 beds and 9 operating rooms. The battalion is made up of a H&S Company, which contains 8 Shock Trauma Platoons under the direction of the S-3; and 3 Surgical Companies each with 60 beds and 3 operating rooms.

(a) Mission. Provide direct and general medical support to the MEF.

(b) Tasks

1. Providing health care through level II care, to include initial resuscitative care, resuscitative surgery, and temporary hospitalization of casualties to the MEF.

2. Providing medical regulating services for the MEF.

3. Provide preventive medicine support to the MEF.

4. Assist in the collection, analysis, and dissemination of medical intelligence.

5. Provide the medical elements for the establishment of casualty decontamination and treatment stations.

6. Provide medical support for management of mass casualties and combat stress casualties.

(4) Dental Battalion. Dental Battalion is the source of all organic dental support capability in the operating force. Each FSSG contains one dental battalion in its organizational structure. Each dental battalion consists of three dental companies which provide clinical support, and an H&S Co for administrative and logistics support.

(a) Mission. Provide general support dental health care to the MEF.

(b) Tasks

1. Provide a comprehensive program of dental health care for the MEF.

2. Coordinate MEF dental health care support requirements.

3. Provide dental detachments, as required, to support MAGTF's smaller than a MEF.

4. Supervise implementation of dental health care delivery programs for the MEF.

(c) General. Dental personnel and equipment are provided from operating force dental assets to assist commanders in meeting this responsibility. The primary peacetime function of operating force dental units is to maintain the dental readiness of the force. In a combat environment, their primary function is to provide both dental care and adjunctive medical care, as required, to preserve and restore the fighting strength of the force. In combat or mass casualty situations, dental personnel may be used to augment medical units, carrying out such functions as triage, lifesaving casualty care procedures, and other medical efforts determined appropriate by cognizant medical authority.

(5) Medical Logistics Company, Supply Battalion, FSSG. Medical Logistics (Med Log) Company provides the organizational structure for centralizing AMAL / ADAL maintenance and management within the FSSG. This company is not a medical / dental organization. Direction and guidance for operation of the Med Log Company is the responsibility of the commanding officer, Supply Battalion, FSSG. The company consists of a company headquarters, equipment repair platoon, and three supply platoons.

(a) Mission. Med Log Company provides general supply and maintenance support for Class VIII material of the MEF.

(b) Tasks

1. Provide general supply support, including establishment and operation of Class VIII supply points and acquisition, receipt, and issue for Class VIII material for the MEF.

2. Provide organizational and intermediate maintenance support for Class VIII equipment of the MEF.

3. Provide support for the packaging, preserving, storage, and maintenance of Class VIII re-supply.

4. Provide for receipt, storage, and issue of Class VIII supplies in support of AMAL / ADAL for MAGTF medical and dental units.

5. Provide technical assistance to MAGTF medical / dental units for the maintenance, inventory, and quality control of unit AMAL's / ADAL's.

(c) Authorized Medical / Dental Allowance List (AMAL / ADAL). AMAL's and ADAL's are specialized equipment and supply assemblages for medical and dental elements to provide HSS under combat conditions. The equipment assemblage contains equipment and reusable material required to establish a basic function (laboratory, operating room, ward, pharmacy, field dental operatory, aid station, etc.). The supply assemblage contains consumable material to support the basic function (laboratory supply, operating room supply, ward supply, pharmacy supply, cold or hot weather supplement, NBC, etc.). For ease in

identification, they are assigned a three digit number of the 600 series.

(d) General. HSS supply encompasses the functions of procurement, initial issue, resupply, and disposition of material necessary to support medical and dental elements organic to the operating forces. As a general rule, requisitions for class VIII material, including blood and blood products, follow the same channels as other classes of supply.

6. AMPHIBIOUS TASK FORCE HSS. Amphibious Task Force (ATF) medical assets, as differentiated from the Landing Force medical assets, consist of medical personnel and facilities organic to ships of the ATF. In amphibious assaults, certain ships of the ATF are reinforced by additional medical personnel and equipment in the form of Fleet Surgical Teams (FST's), Mobile Medical Augmentation Readiness Teams (MMART's), and / or personnel from the Medical Augmentation Program (MAP).

a. Relations with Landing Force Medical Officers. During the planning phase of an amphibious operation, surgeons of both commands coordinate plans to ensure mutual support and fulfillment of all requirements for medical support. These plans are represented in Appendix 9 (Health Services), Annex D, of the operation order.

b. Medical and Dental Facilities of Ships and Landing Craft

(1) LHD. LHD's have the largest medical capability of any amphibious ship currently in use and are designed to function as primary Casualty Receiving and Treatment Ships (CRTS's). Medical spaces include 6 operating rooms and 604 beds. Beds are designated as: 17 intensive care unit (ICU), 4 quiet room, 47 hospital ward, and 536 overflow beds. Dental spaces include two general dental operatories, one maxillofacial surgery operating room, and a prosthetics lab. Included in dental spaces are supportive diagnostic, patient management, and treatment facilities. LHD's require augmentation by an FST and MMART to achieve full casualty treatment capability.

(2) LHA. LHA's are designed to function as primary CRTS's in an amphibious operation. Medical spaces include 4 operating rooms and 365 beds. Beds are designated as: 17 ICU,

2 quiet room, 48 ward, and 298 overflow beds. Dental spaces include one oral surgery operating room and two general dental operatories, with supportive diagnostic, patient management, and treatment facilities. LHA's require augmentation by an FST and MMART to achieve full casualty treatment capability.

(3) LPD. Depending on the ship class, the LPD has an operating room suitable for minor surgery. They have primary care and isolation ward facilities with 12 beds, but lack overflow beds and dental spaces.

(4) LSD. Depending on the ship class, the LSD has an operating room suitable for minor surgery. Their bed spaces include 1 ICU, 2 isolation, 8 primary care, and 100 overflow. They do not have a dental capability.

(5) T-AH (Hospital Ship). The T-AH is a floating surgical hospital, with significant trauma care capabilities, which provides level III care. Support may be provided to an amphibious task force and / or to joint and combined forces. In carrying out this mission, the T-AH will accomplish the following:

(a) Receive patients suffering from wounds, disease, or non-battle injury.

(b) Provide on site emergency and recuperative care to patients until they can be returned to duty or evacuated.

(c) Provide a safe, stable, mobile platform for carrying out the assigned mission.

(d) Provide all necessary personnel, services, and facilities required for the support of the medical facility.

(e) Operate a full medical facility while at sea, day and night with minimal maintenance and refueling.

The T-AH is designed to receive patients primarily by helicopter. It has limited capacity for receiving patients by boat. Initial triage is performed in a casualty reception area. This area has a total of 50 positions, each with piped oxygen, suction, and cardiac monitoring capabilities. The operating complex consists of 12 operating rooms which are equipped for orthopedic, urological, neurological, thoracic, vascular, eyes-ears-nose- throat (EENT), and general surgical

procedures. Adjacent to the operating complex is a recovery room with 20 beds, each with oxygen, suction, and patient monitoring equipment. The ICU consists of 80 beds. Intermediate, light, and limited care wards offer an additional 1000 patient beds. The T-AH has services comparable to those offered in major hospitals, including special gas-generation and water-distillation facilities.

7. HSS OPERATIONS. Regardless of type, size, or mission, HSS is common to all MAGTF operations. Therefore, definitive operational planning for HSS must integrate into the MAGTF operational plan.

a. HSS for a MEU. HSS is provided primarily from a sea-based mode aboard the ships of the ATF. The landing force (LF) receives HSS above its organic capabilities from task-organized components of the FSSG. These components are located in the MEU Service Support Group (MSSG) and include: Shock / trauma platoon, components of H&S Company Medical Battalion, a Medical Logistics Company detachment, a Dental detachment, and components of a Surgical Company.

(1) Prior to commencement of the amphibious assault, landing force medical and dental personnel aboard ATF ships will augment and support ATF medical and dental departments in providing care to embarked personnel of the LF. Equipment and supplies from landing force AMAL's and ADAL's will not be used aboard ship unless authorized by the MAGTF commander in support of an overwhelming emergency.

(2) If it is determined that LF HSS elements of the MSSG will remain afloat and carry out their mission from a sea base, those elements will augment medical departments of the ATF in a combined HSS effort.

(3) LF HSS elements of the MSSG are capable of operations ashore in the AOA, if required. The shore-based element may range from a beach or helicopter evacuation station, manned by a triage / evacuation platoon, to a Shock Trauma Platoon with sections of a Surgical Company.

(4) Regardless of tactical basing of HSS elements, the combat and combat service support elements of the landing force are responsible for collection and initial treatment of casualties.

(5) The dental detachment in support of a MEU is

primarily sea based, using afloat facilities and supplies to render routine dental care while embarked.

b. Assault Phase Operations. During an amphibious assault, recognize that the phased landing of medical facilities in the AOA will vary with the tactical situation and physical environment.

(1) Assault Echelon. During the assault phase, medical support ashore is limited to the constrained capabilities of medical sections organic to combat units. Until BAS's are established ashore, first response medical care for initial assault forces is provided by self-aid, buddy aid, and corpsman of landed rifle platoons.

(a) Infantry BAS's and their personnel are normally divided into two sections, with assigned battalion non-medical litter bearers divided between the two sections. The 1st echelon of a BAS lands with the battalion combat train and establishes in close support of the assault force. The 2d echelon of the BAS lands with the field train, and may be required to establish an evacuation station until relieved by designated evacuation station support elements.

(b) Evacuation station facilities are normally manned by STP's from the supporting MSSG. Evacuation stations are normally established with the Landing Force Support Party (LFSP), and constitute the evacuation section(s) of the LFSP. The primary role of an evacuation station is to evacuate casualties to the designated CRTS.

(c) When evacuation stations attached to the LFSP become operational ashore, 2d echelon elements of BAS's are relieved to conduct their missions in primary support of parent battalions. Following the landing of assault battalions and supporting evacuation stations, the buildup of HSS facilities ashore begins.

(2) Assault Follow-on Echelon. The buildup of landing force HSS facilities ashore begins as soon as the tactical situation permits. These facilities are primarily the task-organized medical battalion elements embarked to support combat operations. The initial facility establishes shore-based capabilities for emergency surgery and temporary casualty holding.

(a) Surface evacuated casualties from landing force units normally flow through shore-based facilities having surgical capability, once those facilities are established. Casualties evacuated by air may bypass shore-based facilities en route to a CRTS.

(b) Normally, routine dental care will not be provided during this phase. Dental personnel will be employed to assist medical personnel in the overall casualty care effort.

(3) Follow-on Forces. When progress of assault units is such that the beachhead is relatively secure, HSS ashore is enhanced and consolidated. The goal is to achieve shore-based care consistent with the expected combat intensity and duration. If a sustained land campaign is envisioned, additional HSS will be provided by fleet hospitals of hospital ships. During this phase, dental personnel may establish dental clinics ashore and resume some degree of routine dental care.

8. **COMBAT CASUALTY REPORTING**. The G-1/S-1 section is responsible for submitting prompt, accurate, and complete casualty reports to higher headquarters. In combat operations, unit corpsmen and medical treatment facilities are primary sources of individual casualty data.

a. Field Medical Card (FMC, DD Form 1380). The purpose of the FMC is to establish patient accountability and provide a means to document assessment of medical condition and medical treatment rendered by HSS personnel. The FMC is to be used as an emergency medical tag for all casualties at the time they are initially treated in the field or field medical facility. The completed FMC is an important medical record that will accompany the casualty through the continuum of care.

b. Identification Tags. Identification tags (Dog Tags) are essential to casualty identification and recording. The Marine and unit are both responsible for ensuring that all information is current and accurate.

9. **MEDICAL REGULATING**. Medical regulating is the action and coordination necessary to arrange for the movement of patients through the levels of care. This process accomplishes the following:

a. Ensures a patient is assigned to a facility capable of providing the required treatment.

b. Ensures the facility has the space required to provide the required service.

c. Ensures facilities do not receive patients they are unable to provide care for, either through lack of required clinical services or non-availability of a bed.

10. TRIAGE / SORTING. Casualties must be continuously evaluated to differentiate between those in need of immediate treatment and those whose treatment can be delayed. Equally important is the need to determine which patients require evacuation to other HSS facilities. Incoming patients create a continuing need for evacuation. The constant flow of sick and injured personnel into HSS facilities can rapidly overwhelm facility capabilities unless there is a system in place for triage and patient movement.

a. Triage Category Codes. At each level of care, incoming patients are classified by the immediacy of treatment required. Five triage category groups have been universally adopted for use:

(1) Immediate Treatment (Group T1, Yellow Tag). To include those requiring emergency life saving resuscitation / surgery. These procedures should not be time consuming and should concern only those patients with a high chance of survival. Examples: respiratory obstruction, accessible hemorrhage, and emergency amputation.

(2) Delayed Treatment (Group T2, Green Tag). To include those badly in need of time-consuming major surgery, but whose general condition permits delay in treatment without unduly endangering life. To mitigate the critical effects of delaying surgery, sustaining treatment such as stabilizing IV fluids, splinting, administration of antibiotics, and relief of pain will be required. Examples: large muscle wounds, fractures of major bones, intra-abdominal and / or thoracic, head or spinal injuries, and uncomplicated major burns.

(3) Minimal Treatment (Group T3, White Tag). To include those with relatively minor injuries who can effectively care for themselves or who can be helped by lesser-trained HSS personnel. Examples: minor lacerations, sprains and strains, abrasions, and minor burns.

(4) Expectant Treatment (Group T4, Red Tag). This group comprises patients who have received serious and often multiple injuries, and whose treatment would be time-consuming and complicated with a low chance of survival. If fully treated they may make heavy demands on medical manpower and supplies.

Until other categories of patients are treated, this group will receive appropriate supportive treatment. These patients should not be abandoned, and every effort should be devoted to their comfort. The possibility of their survival, despite alarming injuries, must always be kept in mind. Examples: severe multiple wounds, severe head or spinal wounds, large doses of radiation, widespread severe burns.

(5) Deceased (Group T5, Black Tag). To include those Killed In Action (KIA) and Died of Wounds Received in Action (DOW). This category will be handled by Graves Registration, if established, or by a unit's Mortuary Affairs Program.

11. PATIENT EVACUATION. Patient evacuation is the timely and efficient transportation of wounded, injured, or ill personnel from the immediate area of operations to, and between, HSS facilities. The mode of evacuation, either ground, aeromedical, or waterborne, will be determined by the tactical situation, availability of assets, the patients condition, and the location of the receiving HSS facility. No patient will be evacuated farther rearward than their medical condition requires or the tactical situation dictates. Supporting HSS units are responsible for evacuation of patients from HSS units forward of the supporting unit's position.

a. Every patient evacuated without sufficient reason imposes unnecessary burdens on:

(1) The patients' unit, which will be undermanned until the patient is returned or replaced.

(2) The replacement system, which must procure, train, and transport a replacement.

(3) The HSS system, which must provide bed space and personnel to care for the patient.

b. Patients being aeromedically evacuated will be assigned priorities for evacuation. Patient evacuation priorities, although related to triage categories, should not

be confused with them. The aeromedical evacuation priorities are as follows:

(1) Routine. Patient requires movement but can wait for a regularly scheduled aircraft.

(2) Priority. Patient requires movement within 24 hours to save life, limb, or eyesight.

(3) Urgent. Patient requires movement as soon as possible to save life, limb, or eyesight. Terminally ill or psychiatric patients are not considered urgent patients.

REFERENCES:

1. FMFM 4. Combat Service Support.
2. FMFRP 1-18. Amphibious Ships and Landing Craft Data Book.
3. MCRP 5-12D. Organization of Marine Corps Forces.
4. MCRP 4-11.2. Patient Movement.
5. MCWP 4-1. Logistics Operations.
6. MCWP 4-11. Tactical Level Logistics.
7. MCWP 4-11.1. Health Service Support Operations.
8. NWP 4-02. Naval Force Health Protection.